

REGISTRATION FORM

PATIENT INFORMATION

Child's Name: _____ Nickname: _____
 First Middle Last
 Gender: ☐ Male ☐ Female Birthdate: _____ Age: ____ School: _____ Grade: ____
 Has your child seen a dentist before? ☐ Y ☐ N If yes, name of last dentist: _____
 Date of last dental visit: _____ Is this an emergency visit? ☐ Y ☐ N
 Are any other children in your family patients of our practice? ☐ Y ☐ N If yes, who? _____
 Has your child had any negative dental experiences? ☐ Y ☐ N If yes, explain: _____
 How would you describe your child's behavior/temperament? _____
 What can we do to make your child as comfortable as possible? _____
 Name of family's general dentist: _____
 How did you hear about our office? _____
 Who may we thank for referring your child to our office? _____

PARENT/GUARDIAN INFORMATION

***** For the first dental appointment, child(ren) MUST be accompanied by parent(s) or legal guardian *****

PARENT 1: ☐ Mom ☐ Dad ☐ Other _____
 Marital Status: ☐ Single ☐ Married ☐ Divorced
 Full Name: _____
 Address (no PO Box): _____
 City: _____ State: ____ Zip: _____
 DOB: _____
 Occupation: _____
 Employer: _____

Please fill in the most acceptable method(s) to contact you about appointments, dental or billing information, and/or leave messages with detailed information:

Home Phone: _____
 Wireless Phone: _____ Text OK? ☐
 Work Phone: _____ Ext: _____
 Email: _____

PARENT 2: ☐ Mom ☐ Dad ☐ Other _____
 Marital Status: ☐ Single ☐ Married ☐ Divorced
 Full Name: _____
 Address (no PO Box): _____
 City: _____ State: ____ Zip: _____
 DOB: _____
 Occupation: _____
 Employer: _____

Please fill in the most acceptable method(s) to contact you about appointments, dental or billing information, and/or leave messages with detailed information:

Home Phone: _____
 Wireless Phone: _____ Text OK? ☐
 Work Phone: _____ Ext: _____
 Email: _____

Who does the child live with? ☐ Both parents ☐ Mother ☐ Father ☐ Other _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____ Phone: _____

DENTAL INSURANCE INFORMATION *(not medical insurance!)*

Primary Insurance Carrier

Subscriber Name: _____

Subscriber ID# or SSN: _____

Relationship of Patient to Subscriber: ☐ Child ☐ Self

Group/Policy #: _____

Employer Name: _____

Insurance company: _____

Insurance phone number: _____

How long have you had this coverage? _____

Secondary Insurance Carrier (if applicable)

Subscriber Name: _____

Subscriber ID# or SSN: _____

Relationship of Patient to Subscriber: ☐ Child ☐ Self

Group/Policy #: _____

Employer Name: _____

Insurance company: _____

Insurance phone number: _____

How long have you had this coverage? _____

In order to comply with most insurance companies, please sign below so that we may keep your signature on file.

I authorize the release of any information relating to these claims.

Name: _____ Relationship to patient: _____ Date: _____

Signature: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use of your personal health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person: Dr. James Han or Office Manager
Address: 1530 Noriega Street, 1st FL, San Francisco, CA 94122
Telephone: (415) 681-3220 Fax: (415) 681-3219
Email: info@HanPediatricDentistry.com

Given the layout of our office, from time to time, conversations may be overheard by others. If you object to the fact that you may overhear other patients' health information, or that your child's health information may be overheard by another, please let us know and we will be sure to either place you in a completely private room or reschedule your appointment according to your needs.

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Name: _____ Relationship to patient: _____ Date: _____

Signature: _____